471-000-83 Nebraska Medicaid Billing Instructions for Hospital Services

The instructions in this appendix apply when billing Nebraska Medicaid, also known as the Nebraska Medical Assistance Program (NMAP), for Medicaid-covered services provided to clients who are eligible for fee-for-service Medicaid or enrolled in the Nebraska Health Connection Medicaid managed care plan Primary Care +. Medicaid regulations for hospital services are covered in 471 NAC 10-000.

Claims for services provided to clients enrolled in a Nebraska Medicaid managed care health maintenance organization plan (e.g., Share Advantage) must be submitted to the managed care plan according to the instructions provided by the plan.

NOTE: Billing instructions for the following services are in separate appendices -

- Home health agency services (see 471-000-57);
- Mental health/substance abuse services (see 471-000-64);
- Federally qualified health center services (see 471-000-76);
- Rural health clinic services (see 471-000-77); and
- Nursing facility services (see 471-000-82).

For a complete listing of billing instructions for all services, see 471-000-49.

Third Party Resources: Claims for services provided to clients with third party resources (e.g., Medicare, private health/casualty insurance) must be billed to the third party payer according to the payer's instructions. After the payment determination by the third party payer is made, the provider may submit the claim to Nebraska Medicaid. A copy of the remittance advice, denial, explanation of benefits or other documentation from the third party resource must be submitted with the claim.

For instructions on billing Medicare crossover claims, see 471-000-70. For clients who do not have Medicare Part A coverage or who have exhausted Medicare Part A benefits, all Medicare Part B covered services must be submitted to Medicare prior to billing Medicaid for inpatient hospital services.

Verifying Eligibility: Medicaid eligibility, managed care participation, and third party resources may be verified from –

1. The client's monthly Nebraska Medicaid Card or Nebraska Health Connection ID Document. For explanation and examples, see 471-000-123;
2. The Nebraska Medicaid Eligibility System (NMES) voice response system. For instructions, see 471-000-124; or
3. The standard electronic Health Care Eligibility Benefit Inquiry and Response transaction (ASC X12N 270/271). For electronic transaction submission instructions, see 471-000-50.

CLAIM FORMATS

Electronic Claims: Hospital services are billed to Nebraska Medicaid using the standard electronic Health Care Claim: Institutional transaction (ASC X12N 837). For electronic transaction submission instructions, see 471-000-50.

Paper Claims: Hospital services are billed to Nebraska Medicaid on Form CMS-1450 (UB-92), "Health Insurance Claim Form." Instructions for completing Form CMS-1450 are in this appendix.

Share of Cost Claims: Certain Medicaid clients are required to pay or obligate a portion of their medical costs due to excess income. These clients receive Form EA-160, "Record of Health Cost – Share of Cost – Medicaid Program" from the local HHS office to record services paid or obligated to providers. For an example and instructions on completing this form, see 471-000-79.

MEDICAID CLAIM STATUS

The status of Nebraska Medicaid claims can be obtained by using the standard electronic Health Care Claim Status Request and Response transaction (ASC X12N 276/277). For electronic transaction submission instructions, see 471-000-50.

Providers may also contact Medicaid Inquiry at 1-877-255-3092 or 471-9128 (in Lincoln) from 8:00 a.m. to 5:00 p.m. Monday through Friday.

CMS-1450 FORM COMPLETION AND SUBMISSION

Mailing Address: When submitting claims on Form CMS-1450, retain a duplicate copy and mail the ORIGINAL form to –

Medicaid Claims Processing
Health and Human Services Finance and Support
P. O. Box 95026
Lincoln, NE 68509-5026

Claim Adjustments and Refunds: See 471-000-99 for instructions on requesting adjustments and refund procedures for claims previously processed by Nebraska Medicaid.

Claim Example: See 471-000-51 for an example of Form CMS-1450.

Claim Form Completion Instructions: CMS-1450 (UB-92) completion requirements for Nebraska Medicaid are outlined below. The numbers listed correspond to the CMS-1450 form locators (FL) and are identified as required, situational, recommended or not used. Unlabeled form locators are not included in these instructions. See 471-000-78 for a summary of form locator requirements for all services billed on Form CMS-1450.

These instructions must be used with the complete CMS-1450 (UB-92) claim form completion instructions outlined in the Nebraska Uniform Billing Data Element Specifications. The Nebraska Uniform Billing Data Element Specifications document is available from the Nebraska Uniform Billing Committee through the Nebraska Hospital Association.

FL	DATA ELEMENT DESCRIPTION	REQUIREMENT
1.	**Provider Name, Address & Telephone Number**	**Required**
3.	**Patient Control Number**	**Required**

The patient control number will be reported on the Medicaid Remittance Advice.

4.	**Type of Bill**	**Required**
5.	**Federal Tax Number**	**Recommended**
6.	**Statement Covers Period**	**Required**
7.	**Covered Days**	**Situational**

Required on all inpatient claims. The admission date may be submitted as a covered day. The discharge date may not be submitted as a covered day, unless the discharge occurs on the same date as admission. If the admission and discharge occurs on the same date, one covered day may be billed.

Not used on outpatient claims.

8.	**Non-Covered Days**	**Situational**

Use if applicable.

9.	**Coinsurance Days**	**Not Used**
10.	**Lifetime Reserve Days**	**Not Used**
12.	**Patient Name**	**Required**

The patient is the person that received services. When billing for services provided to the ineligible mother of an unborn child, enter the name of the mother (see 471 NAC 1-002.02K).

13.	**Patient Address**	**Recommended**

The patient is the person that received services.

14.	**Patient Birthdate**	**Required**

The patient is the person that received services.

15. Patient Sex **Required**

The patient is the person that received services.

16. Patient Marital Status **Not Used**

17. Admission/Start of Care Date **Situational**

Required on all inpatient claims.

Required on outpatient claims for surgical procedures, emergency, labor, treatment, and observation rooms, dialysis, cardiac rehab, electroconvulsive therapy, physical therapy, occupational therapy, and speech therapy.

18. Admission Hour **Situational**

Required on all inpatient claims.

Required on outpatient claims for surgical procedures, emergency, labor, treatment, and observation rooms, dialysis, cardiac rehab, electroconvulsive therapy, physical therapy, occupational therapy, and speech pathology.

19. Type of Admission/Visit **Required**

20. Source of Admission **Required**

21. Discharge Hour **Situational**

Required on all inpatient claims.

Required on outpatient claims for surgery, emergency room, labor room and observation room services.

22. Patient Status **Situational**

Required on all inpatient claims. Required on outpatient claims for surgery, emergency room, labor room and observation room services.

Interim DRG inpatient claims require physician documentation of medical necessity for length of stay. Interim claims must be a minimum of 60 consecutive days with anticipated stay of an additional 60 consecutive days, unless one of the following conditions is met -

a) the client is no longer eligible for Nebraska Medicaid;
b) the client is eligible for Medicare on the first day of the next month; or
c) the service is exempt from DRG payment (e.g., rehab care).

The final claim must list all charges for the entire inpatient stay. Interim DRG payments are deducted from the final payment.

23. Medical/Health Record Number **Required**

24-30. Condition Codes **Situational**

Use if applicable.

32-35. Occurrence Codes and Dates **Situational**

Required for traumatic diagnoses. Required on outpatient claims for dialysis, cardiac rehab, electroconvulsive therapy, physical therapy, occupational therapy, and speech pathology. Use other occurrence codes if applicable.

36. Occurrence Span Code and Dates **Situational**

Use if applicable.

37. Internal Control Number (ICN)/ Document Control Number (DCN) **Situational**

Required on adjustments.

38. Responsible Party Name and Address **Not Used**

39-41. Value Codes and Amounts **Situational**

Use if applicable.

42. Revenue Code **Required**

43. Revenue Description **Situational**

When using miscellaneous and not otherwise classified (NOC) procedure codes, a complete description of the service is required.

44. HCPCS/Rates/HIPPS Rate Codes **Situational**

Rates are required on inpatient claims for accommodation rooms and on outpatient claims for dialysis services.

HCPCS procedure codes are required on inpatient claims for “other therapeutic services” (revenue codes 940 and 949). HCPCS procedure codes are required on all outpatient claims except pharmacy, supplies and dialysis. Up to four procedure code modifiers may be entered for each procedure code.

HIPPS rate codes are not used.

45. Service Date **Situational**

Required on outpatient claims with date spans (FL6) greater than one calendar day, except dialysis, cardiac rehab, and ambulatory room and board services.

46. Units of Service **Required**

Units must be whole numbers. No decimals or fractions are permitted.

47. Total Charges (by Revenue Code Category) **Required**

Total charges must be greater than zero unless two or more operative procedures during a single session are billed. Only the first procedure requires a charge. Do not submit negative amounts.

48. Non-Covered Charges **Situational**

Enter only Nebraska Medicaid non-covered charges. Do not submit negative amounts.

50. Payer Identification **Not Used**

51. Provider Number **Required**

Enter the eleven-digit Nebraska Medicaid provider number as assigned by Nebraska Medicaid (example: 123456789-12). All payments are made to the name and address listed on the Medicaid provider agreement for this provider number.

52. Release of Information Certification Indicator **Not Used**

53. Assignment of Benefits Certification Indicator **Not Used**

54. Prior Payments - Payers and Patient **Situational**

Enter any payments made, due, or obligated from other sources for services listed on this claim unless the source is from Medicare. Other sources may include health insurance, liability insurance, excess income, etc. A copy of the explanation of Medicare or insurance remittance advice, explanation of benefits, denial, or other documentation must be attached to each claim when submitting multiple claim forms.

DO NOT enter previous Medicaid payments, Medicaid copayment amounts, Medicare payments, or the difference between the provider's billed charge and the Medicaid allowable (provider "write-off" amount).

55. Estimated Amount Due **Not Used**

58. Insured's Name **Required**

When billing for services provided to the ineligible mother of an eligible unborn child, enter the name of the unborn child as it appears on the Nebraska Medicaid Card or Nebraska Health Connection ID Document.

59. Patient's Relationship to Insured **Required**

Use patient relationship code 18 for all claims.

60. Certificate/Social Security Number/Health Insurance Claim/Identification Number **Required**

Enter the Medicaid client's complete eleven-digit identification number (example: 123456789-01). When billing for services provided to the ineligible mother of an eligible unborn child, enter the Medicaid number of the unborn child.

61. Insured Group Name **Situational**

Recommended when Nebraska Medicaid is the secondary payer.

62. Insurance Group Number **Situational**

Recommended when Nebraska Medicaid is the secondary payer.

63. Treatment Authorization Code **Not Used**

64. Employment Status Code of the Insured **Not Used**

65. Employer Name of the Insured **Not Used**

66. Employer Location of the Insured **Not Used**

67. Principal Diagnosis Code **Required**

Enter the ICD-9-CM code describing the principle diagnosis (i.e., the condition established after study to be chiefly responsible for occasioning the admission of the patient for care). The COMPLETE diagnosis code is required. A complete code may include the third, fourth, and fifth digits, as defined in ICD-9-CM.

68-75. Other Diagnosis Codes--ICD-9-CM **Situational**

Enter the ICD-9-CM codes corresponding to conditions that co-exist at the time of admission, or that develop subsequently, and that affect the treatment received and/or the length of stay.

76. Admitting Diagnosis/Patient's Reason for Visit **Situational**

Required on all inpatient claims.

Required on outpatient claims for emergency room services.

77. External Cause of Injury Code (E-Code) **Situational**

Required if the principal diagnosis is trauma.

79. Procedure Coding Method Used **Not Used**

80. Principal Procedure Code and Date **Situational**

ICD-9-CM surgical procedure code is required on inpatient claims for surgical procedures. The procedure date is required when a code is reported.

ICD-9-CM surgical procedure codes are not allowed on outpatient claims.

81. Other Procedure Codes and Dates **Situational**

ICD-9-CM surgical procedure code is required on inpatient claims for multiple surgical procedures. The procedure date is required when a code is reported.

ICD-9-CM surgical procedure codes are not allowed on outpatient claims.

82. Attending Physician ID **Required**

Enter the practitioner's license number. The practitioner license number must begin with the two-digit state abbreviation followed by the state license number (example: NE123456). Enter the attending practitioner's last and first name.

83. Other Physician ID **Not Used**

84. Remarks **Situational**

Use to explain unusual services and to document medical necessity, for example, when unit limitations are exceeded, and for ambulatory room and board services. Required for outpatient stays greater than 24 hours.

85. Provider Representative Signature **Required**

The provider or authorized representative must sign the claim form. A signature stamp, computer-generated, or typewritten signature will be accepted.

86. Date Bill Submitted **Required**

The signature date must be on or after the last date of service listed on the claim.